MENTAL HEALTH PLANNING AND ADVISORY COUNCIL
March 18, 2015 9:00 am to 3:30 pm
Iowa Vocational Rehabilitation, Jessie Parker Building, Knudsen Room
510 E 12th St Des Moines, IA
MEETING MINUTES

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS PRESENT:

Teresa Bomhoff
Kenneth Briggs Jr.
Jim Chesnik
Jackie Dieckmann
Jim Donoghue
Kathleen Goines
Kris Graves
Marlene Jessop (phone)
Julie Kalambokidis
Gary Keller (phone)
Anna Killpack
Sharon Lambert (phone)
Todd Lange
Craig Matzke
Sally Nadolsky
Tammy Nyden
Lori Reynolds (phone)
Donna Richard-Langer (phone)
Brad Richardson
Jim Rixner
Lee Ann Russo
Joe Sample
Dennis Sharp
Kathy Stone (phone)
Kimberly Wilson
Lisa Wunn

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL MEMBERS ABSENT:

Julie Hartman
Amber Lewis
Christina Schark
Gretchen Tripolino
Jennifer Vitko
Ann Wood

OTHER ATTENDEES:

Theresa Armstrong	DHS, MHDS, Community Services & Planning Bureau Chief
Trisha Barto	DHS, Child Welfare and Emergency Services
Lisa D'Aunno	The University of Iowa School of Social Work
Connie Fanselow	DHS, MHDS, Community Services & Planning
Diane Funk	The University of Iowa, Center for Child Health Improvement and Innovation
Deborah Johnson	Iowa Medicaid Enterprise, Long Term Care
Liz Matney	Iowa Medicaid Enterprise, Managed Care
Vickie Miene	The University of Iowa, Center for Child Health Improvement and Innovation
Tia Miller	Embrace Iowa
David Mitchell	Vocational Rehabilitation
Peter Schumacher	DHS, MHDS, Community Services & Planning
Rick Shults	DHS, MHDS Division Administrator
DJ Swope	Iowa Department on Aging

COMMITTEE MEETINGS
The Nominations Committee met from 9:30 am to 10:00 am. Ken Briggs, Jim Chesnik, Brad Richardson, and Dennis Sharp participated.

WELCOME AND INTRODUCTIONS
David Mitchell, Administrator of Iowa Vocational Rehabilitation Services, welcomed the Council to the Jessie Parker Building, noting that IVRS has a commitment to supporting Iowans with mental illness and other mental health concerns in preparing for and finding employment and leading productive lives.

Chair Teresa Bomhoff called the meeting to order at 10:00 a.m. and led introductions. Quorum was established with 20 members present and 6 participating by phone.

APROVAL OF MINUTES
The Motion to approve the minutes from the January 21, 2015 meeting was approved unanimously.

Nominations Committee Report – Committee Chair Dennis Sharp reported that the Committee is filling one vacancy on the council for an "Other" position:

- Rhonda Shouse is the parent of an adult with a serious mental illness, and an advocate for people with mental health issues. She has served on this council before for six years, and says she feels there is more work to be done in Iowa regarding mental health issues. The Committee recommends Rhonda for the vacant "other" position.

On behalf of the members of the Nominations Committee, a motion was made and seconded to approve Rhonda Shouse as a new Council member. The motion passed unanimously.

Dennis Sharp reported that the Committee is filling one vacancy on the Nominations Committee. The Committee recommends Kathleen Goines. Joe Sample made a motion to approve Kathleen Goines as a new member of the Nominations Committee. Ken Briggs seconds the motion. The motion passed unanimously.

STATE AGENCY REPORTS

DHS/MHDS Update- Theresa Armstrong
Theresa announced the hiring of Connie Fanselow into a new position within DHS/MHDS collaborating with stakeholders and providers to develop policy that pertains to people with intellectual disabilities and developmental disabilities.

Theresa also announced Rose Kim as a new staff member through the Center for Disabilities and Development. She is the new Quality Improvement Analyst who will be collecting and analyzing outcomes data. She has already started working with the Iowa Association of Community Providers and with the MHDS regions discussing what outcomes should be measured and how providers fit in.

DHS has a new Request for Proposals posted for the Projects for Assistance in Transition from Homelessness (PATH) program. This would be for a SAMHSA grant to provide services to people who are mentally ill and also experiencing homelessness in 5 communities in Iowa. DHS works on six year contracts and this is the sixth year. DHS must go back through the procurement and contracting process.

Discussion:
Currently these services are being provided in Des Moines, Iowa City, Davenport, Cedar Rapids, and Dubuque. These services are provided in populated areas where the need is greatest. There may be providers in different cities depending on the bids that are received. Currently contracts are primarily with Community Mental Health Centers except for Des Moines, which is contracted with Primary Health Care. Applications are due on May 1st, Current contracts expire on June 30th, and the new contracts will begin on July 1st.

Legislative Updates:
HF 449: this is a bill for inpatient psychiatric bed tracking. DHS will develop an inpatient bed tracking system for magistrates, emergency rooms, and others to use when patients are committed. Hospitals will be required to keep the system up to date. This will cut down on the number of phone calls made to find inpatient beds, but will not eliminate them. DHS has been working on this project already based on a Legislative Report submitted in December 2013 to guide DHS. The system will be used for both adults and children. This could include hospitals in neighboring states, but would require separate legislation to allow Iowa to contract with out of state facilities. It will not be mandatory for any facility to use the system, however the Iowa Hospital Association has been working collaboratively on this project.

HF 551/SF 440: Allows MHDS regions, and counties for substance use disorder services, to contract with facilities in bordering states to receive inpatient psychiatric commitments.

HF 468: Would give County Board Supervisors the authority to appoint Mental Health Advocates rather than the courts. Those advocates would be employed and supervised by counties. This is in response to recommendations from a judicial workgroup asking for more consistency to the mental health advocacy system. This legislation does not define the responsibilities of Mental Health Advocates.

Iowa Medicaid Enterprise Update- Deb Johnson and Liz Matney
Medicaid Modernization: Iowa High Quality Health Care Initiative

Currently Medicaid is a large program with approximately 560,000 enrollees and a budget of approximately $4.2 billion. Medicaid in Iowa has seen a growth of 73% since 2003, and IME is projected to see another 21% growth over the next few years. IME already uses managed care in the form of Iowa Plan for Behavioral Health, a Health Management Organization (HMO) contract with Meridian, The Iowa Health and Wellness Planthat operates through an HMO, Primary Care Case Management (PCCM) also known as Medipass, Non-Emergency Medical Transportation (NEMT), and the Program for All-inclusive Care for the Elderly (PACE). Liz notes that these programs are very specific in the populations they serve and the service they provide, which creates fragmented care. The challenge IME is attempting to address is the lack of a single unified system of care. These systems do communicate, but often they do not communicate well enough. Many enrollees do not receive overall care coordination.

Liz expressed concern that payment is not tied to patient outcomes or client satisfaction. Fee for service pays based on volume, not quality of outcomes. Liz states that the current system does not adequately manage the care for enrollees, and this leads to more expensive services. 28% of Medicaid enrollees are older adults or persons with disabilities, but account for 71% of total Medicaid costs. These individuals may or may not have case management through community-based case managers, integrated health homes or chronic condition health homes.

Currently, thirty-nine states and the District of Columbia contract with managed care organizations for Medicaid services. Nationally over half of Medicaid enrollees are on managed care plans. IME is talking to several states who have implemented Managed Care plans. Some states have done so recently, and others have older and more established plans. IME is learning about the hurdles and challenges associated with implementing a managed care plan.

The state will pay the MCOs a per member per month (capitated) rate determined by an actuarial analysis. These payments added together will allow the MCO to manage the care of their members. IME plans to move the vast majority of their members into a managed care system. Medicaid Modernization will create a single system of care that will oversee all of members' health services, and coordinate them to provide access and prevent duplication.

"The Iowa High Quality Health Care Initiative" is a term used interchangeably with "Medicaid Modernization" and refers to the same plan. IME is looking to contract with two to four MCOs who can operate and manage care for people statewide. IME intends to have at least two so that members will have a choice, and will not exceed four because if an MCO doesn't have enough members, they will not be able to spread risk enough to be cost-effective. Governor Branstad estimates saving $51.3 million in the first six months due to increased efficiency. Liz stressed that the program will not save

money due to cutting services, but by removing redundant services and by preventing readmissions into hospitals.

IME will be measuring outcomes from MCOs. Performance measures and performance targets will be required from contractors. All MCOs will have an external quality review, and the results will be reported to CMS. IME will also have expectations and performance targets for the MCOs. There is a pay-for-performance aspect in the RFP where IME will withhold a small portion of the capitated payment, and the MCO will only receive that portion if they meet quality standards. In the first year, the standards will mostly be operational standards such as paying claims in a timely manner and member authorizations being processed quickly. Within a year or two, these standards will shift into member outcomes. The outcomes are not expected to be fixed, as IME's priorities change and they see needs change, performance outcomes may change to reflect that. Liz invites input on performance measures that stakeholders think should be included.

The vast majority of Medicaid members will be included in this initiative. PACE members are not automatically included. PACE members are not included because they are already in an all-inclusive managed care system. Members who are on another insurance plan, but having their premiums paid by IME such as the Health Insurance Premium Payment Program (HIPP) or the Medicare Savings Program, and people with retroactive eligibility will not be included. Retroactive eligibility will be paid on a fee for service basis, and then they will be assigned prospectively. American Indians and Alaskan Natives can opt in, but are not automatically assigned. Undocumented persons who are eligible for emergency services are not included because they are in the system for a short period of time and managed care would not provide a benefit.

All traditional Medicaid services will be included with the exception of dental services. Liz says this is due to the success of the Dental Wellness Program, which will continue. MFP services will not be included, and will continue be operated through a grant as they are today.

When members enroll, they will be given an opportunity to select an MCO. If they do not make a selection, they will be tentatively assigned to one. Members will be able to choose a new MCO annually at the time of re-enrollment, and they will have the ability to change at any time for good cause.

There will be transition periods within which members can keep their current providers. After the transition period, MCOs will be able to manage their network how they see fit. MCOs will be required to contract with any provider who wants to contract with them. For physicians, members will be able to keep them for at least six months. CMHCs and long term care (which includes HCBS) has a two year transition period. Premium requirements will not change for members. If a member has a care manager, the MCO must allow the member to keep their case manager for at least six months, however it is expected that all case management functions will be assumed by the MCO within a year. If services are reduced, removed or modified, the member will have appeal rights

with the MCO, and if the dispute is not resolved there, they can request a hearing with the state. MCOs must honor existing care authorizations for at least 3 months for the first year, and after the first year, they must honor existing authorizations for at least thirty days. For the first six months of operation, reimbursement rates will stay the same. After six months, there will be a rate adjustment taking risk factors into account, but rates cannot fall below the current Medicaid rates.

The state was awarded a State Innovation Model Grant in December 2014 to help the state continue to redesign the payment system. IME is planning on contracting with Accountable Care Organizations (ACOs) and pursuing shared savings. MCOs will be required to use the Value Index Scores. MCOs will also need to identify the percentage of value-based contracts in place by 2018. These contracts could be shared savings arrangements, pay for performance contracts, bundled payments for episodic care as opposed to fee for service, pay for improvement of quality metrics, etc.

IME will continue to read all comments submitted to the Medicaid Modernization Mailbox, even after the close of the comment period.

IME had originally planned for an 1115 demonstration waiver from CMS, but consultation with CMS, a 1915b/1915c combination waiver program may be pursued, and IME will be seeking public comment around June of this year. There have been questions about what happens if CMS does not approve the waivers by January 1, 2016. Liz says if that were to happen, Iowa will not be able to use federal money. However, IME is working with CMS every step of the way in the waiver process. IME has received constant input from CMS over the past few weeks and CMS will see every part of the application in some form before it is formally submitted, so IME is hoping for an expedited review process.

Stakeholders are encouraged to ask questions and provide feedback. Information on future public meetings, the questions and comments email address, and the link to the RFP itself can be found at
https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

Discussion:
Jim Rixner expressed concern that after several changes to DHS and the Iowa Medicaid program with the Iowa Health and Wellness Program, another change to Medicaid will be very difficult for people with mental illness.

Brad Richardson asked a question about the Value Index Score and what makes up the VIS. Liz asked that those questions be submitted to medicaidmodernization@dhs.state.ia.us where they can be answered publicly. The VIS does contain seven “Domains” which are Member Experience, Primary and Secondary Prevention, Tertiary Prevention, Population Health Status, Continuity of Care, Chronic and Follow-Up Care, and Efficiency.

Tammy Nyden asked if MCOs would have an incentive to avoid high-risk patients. Liz answered that MCOs will only be allowed to disenroll members for very specific reasons, and high risk patients will be protected that way. There will be a risk adjustment to the MCO's rates after six months to compensate for differing risk pools. There is also concern that the outcomes measurement system is being built before the outcomes measures are decided.

Jim Rixner asked how credentialing would be handled under this system and whether providers will need to credential with all four MCOs separately, and if there is a risk of the MCOs limiting the number of providers in a given market, and refusing to credential willing providers to limited the number. Liz asked Jim to submit that question formally to the Medicaid Modernization Mailbox. Teresa Bomhoff said that there is a possibility of a central credentialing center within Medicaid so providers can meet one set of standards.

Tammy Nyden expressed concerned that managed care will incent MCOs to avoid high-risk patients. Liz answered that there are very specific and strictly regulated reasons for why an MCO would be allowed to disenroll a member. They will not be allowed to discontinue care to a patient because they are high-cost. There is also protection for MCOs with higher-risk patients by adjusting rates after six months to account for risk. Tammy is also concerned about patients with inconsistent and unpredictable health needs, and the possibility of breaking up a successful care team due to provider networks. Liz said she does not foresee a large change in provider networks due to federal access standards.

Lisa Wunn asked if this will affect the number of providers who are willing to accept Medicaid. Liz responded that MCOs can offer provider incentives and create what may be considered a better environment for providers.

Anna Killpack asks what happens if patients are not able to answer for themselves or if there is a disagreement about what is necessary. Liz answers that there will be a stakeholder advisory group to address the systemic issues and help IME address that need on an individual level.

Iowa Peer and Family Peer Support Training Program- Vickie Miene, Diane Funk, and Lisa D'Aunno

Vickie Miene is the Executive Director for the Center for Childhood Health Improvement and Innovation. She has a background in clinical psychology and is a licensed mental health therapist. She is a former foster parent and has adopted four children with special mental health needs.

Diane Funk is the program coordinator for the Peer Support Specialist (PSS) and Family Peer Support Specialist (FPSS) project. She has more than twenty years of experience as a peer advocate in the domestic abuse and sexual assault field, and worked with the State of Iowa in the 1980s to write the certifications for centers and sexual assault advocates.

Lisa D'Aunno is the Training Director for the National Resource Center for Family-Centered Practice at The University of Iowa School of Social Work. She is has a law degree and has primarily represented children and parents in juvenile court and child-abuse and neglect cases. Before this position, she was the director for the National Resource Center for In-Home Services at The University of Iowa.

The Center for Child Health Improvement and Innovation (CCHII) was established to conduct health outcomes and systems research in pediatric and community practice. CCHII is taking the lead in this project in a partnership with the National Resource Center for Family-Centered Practice, ASK (Access for Special Kids) Resource Center, NAMI (National Alliance on Mental Illness) Iowa, and Child Specialty Clinics. The Iowa Peer and Family Peer Training Program is a project to provide comprehensive training for Iowa's peer support and family peer support workforce. CCHII was awarded the contract for this initiative through a DHS request for proposal (RFP) process.

The RFP divides the project into three work plans. Work Plan One is focused on recruiting and training and has been submitted to DHS. CCHII intends to recruit, train, and retain additional PSS and FPSS for the workforce in Iowa. To this end they are reviewing existing curricula for similar programs in Iowa and engaging stakeholders in a series of listening and feedback sessions across the state. Advisory committees will be doing peer review to maintain quality and regulate the curriculum and certification requirements. A draft of the curriculum is due by July 16. CCHII intends to use a co-trainer model, pairing a person with lived experience (the peer trainer) and another person with training experience (the partner trainer) who may or may not have lived experience with mental illness or as a parent or family member. Training is anticipated to begin in July, and training sessions will be held in four locations around the state.

In order to improve retention of Peer Support Specialists and Family Peer Support Specialists in the workforce, CCHII will be utilizing realistic job previews so that prospective PSS and FPSS have an accurate picture of their role and responsibilities before they take on the job.

Work Plan Two will be submitted in August and is focused on reviewingdeveloping certification for PSS and FPSS. CCHII must develop a set of competencies that stakeholders agree all peer support professionals should have. They are reviewing nationally recognized curricula to find well-accepted competencies that already exist. There will be more listening and feedback sessions to seek stakeholder input.

CCHII will develop a new certification process for Family Peer Support, and to evaluate the current Peer Support certification process and see whether or not it lines up with the competencies they will be developing. There will also be a process by which people who are currently working in this field can qualify for this new certification.

Work Plan Three is focused on continuing education and training for PSS, FPSS, and those who will be supervising them. This work plan will be submitted in October. CCHII will have another collaborative process with stakeholders to determine the amount and form of continuing education will be necessary to retain certification.

Discussion: The training CCHII will be developing will not take anything away from people who have done training in the past using other models. There was a question about the role of The Appalachian Consulting Group ACG in this project. ACG developed the Georgia model of peer support training that has been used by the Iowa Peer Support Training Academy. CCHII will contract with ACG for the first year to assist with developing new training models for PSS and FPSS. The locations and settings of the training sessions have not yet been decided. Locations where people are comfortable and that are cost effective will be identified.

A break was taken for lunch at 12:45 pm

The meeting resumed at 1:25 pm

DHS/MHDS Update Continued- Theresa Armstrong
Legislative Update Continued:
HF 251: Allows MHDS regions to contract with private transportation companies to transport people for the purpose of receiving treatment for substance use disorders or mental illness.

SF 386: Proposes the establishment of a stakeholder group for adults who are sexually aggressive, combative, or have unmet geropsychiatric needs in nursing facilities.

SF 401: This bill would require sub-acute services to be available for involuntary committals. Currently, involuntary committals must be made to the acute level of care. There is also an amendment to increase the number of sub-acute beds in the state from fifty to seventy-five, as well as remove the requirement for the facility to use certificate of need beds for sub-acute services. Facilities will still need to be certificate of need facilities. Bob Lincoln has developed a plan to build a sub-acute facility to be used for involuntary committals, and this amendment would remove some, but not all, of the restrictions he has encountered.

SF 463: Is a “clean-up” bill that updates language related to MHDS redesign, for example, changing references from “county” to “MHDS region” where appropriate.

SF 464: Renews the Prevention of Disabilities Policy Council that was set to sunset at the end of this fiscal year. The bill explains the role and make-up of the Council and re-establishes it indefinitely.

SF 162: This is a bill that defines in what settings people can identify bullying and allowing students who have experienced bullying to transfer to a different school.

HSB 177: This bill would allocate 70% of the Community Mental Health Services Block Grant funding to MHDS regions instead of Community Mental Health Centers. Rather than being administered by DHS, the funds would be administered by the MHDS regions. The regions would be required to comply by all the same federal requirements that the state does. There is concern that the regions will not be able to administer those funds as efficiently and effectively as the state has in the past.

SF 396: Motor fuel site access bill: Requires gas stations to have a button by fuel pumps to notify gas station employees that someone needs assistance. The button must be usable with a closed fist.

SF 452: Forms a Medicaid Transformation Oversight Commission of legislators to meet quarterly and oversee the Medicaid Modernization project. They will have a specific charge to protect vulnerable populations within Medicaid membership.

Monitoring and Oversight Committee- Jackie Dieckmann
Jackie presented recommendations to DHS, developed by the Monitoring and Oversight Committee, and adopted by the Council for future use of MH Block Grant funds:

Priority 1: Increase mental health training for first responders and police. First responders and police often assist people with mental health issues in times of crisis, and the MHPC recommends that Mental Health Block Grant funds be used to train first responders to recognize mental health crisis situations and properly address them. Jim Rixner shared a story about police and ER staff not recognizing that a patient was having a mental health episode. Jackie shared a story about medical staff who did not understand her son's complex mental health and physical health needs. Rick Shults says he appreciates receiving feedback and advice on how to spend the available MHBG funds, but recognizes funds will not be available to pursue all the Council's recommendations. He said he would like the Council to identify their top priorities. Craig Matzke mentioned that clinical staff and nurses have to go through trauma training, and that a mandated online training module for police officers could be a starting point for a project like this.

Jim Rixner and Anna Killpack said they would like to encourage the development of more therapeutic schools in Iowa. Currently, there are several private schools in Iowa that are designed to deal with special needs. Most of them are focused on behavior modification with reward-based incentives. Anna has only found one that is focused on collaborative problem-solving and trauma-informed care. Anna believes that this is an alternative that needs to be available for kids in Iowa. The first steps could be low or no cost items, including determining the need in the state and beginning to collaborate with the Department of Education.

Rick Shults said he looks forward to working with these priorities further. He would like to see a work plan that ties money to projects, and activities to projects that do not require funding.

Teresa Bomhoff introduces DJ Swope, who has recently begun working with the Iowa Department on Aging as their mental health liaison. She will be coming to some of the MHPC meetings in the future along with Joe Sample. Teresa also welcomes Trisha Barto, who will be taking over for Jim Chesnik from DHS. Gretchen Tripolino is retiring from her position at the Independence Mental Health Institution on March 31, and her membership on the Council will also end. DHS will work on identifying a new mental health services representative.

Corrections- Dr. Gary Keller
John Baldwin has retired and the new Corrections Director is Jerry Bartruff. Gary said there are still too many patients ending up in corrections rather than treatment. The Department of Corrections currently has six fulltime psychiatrists, and might have one more who will be working with community health care in the near future. The new position will be working with people who have been discharged or are on parole.

Education- Teresa Bomhoff
The Iowa Department of Education's Learning Supports Conference will be held in Des Moines on April 22 and 23 at the Iowa Events Center. The conference is open to any school or AEA personnel, or anyone involved in mental health at no charge.

IME- Sally Nadolsky
IME is functioning without a Medicaid Director, but they will be starting with interviews soon after a national search. Sally noted that the most recent similar hires in other states have been internal.

Sally mentioned some pending bills:

SF 452, is the bill Theresa Armstrong talked about that would create a Medicaid Oversight Committee and Sally encouraged everyone to read the bill and provide feedback.

HF 317: This bill requires IME to write rules pertaining to telehealth services in Iowa. Currently it is unclear how extensively telehealth is being utilized, or the extent of telehealth infrastructure in Iowa.

There is a small bill that adds additional funding to the EMS system. Sally mentions that there is a bill to mandate that Area Agencies on Aging (AAAs) do depression screenings on all of the individuals they serve. A bill on wheelchairs would require that the people who "fill" the wheelchair prescription would need to be certified technology specialists. Currently, most wheelchairs for children are fit by AEA personnel, and Sally said it is unclear whether they would pursue certification or how this would affect access. Sally is

involved in a work project in juvenile court which is attempting to get screenings and functional referrals for pregnant women who are screened to have a substance abuse and mental health issue.

Ken Briggs mentions a bill (HF 527) that would remove the minimum age for someone to use a gun at a firing range. Ken is concerned that removing these restrictions would allow greater access to guns for people who are experiencing mental health crises.

IDA- Joe Sample
IDA is working on the No-Wrong-Door project and has a federal grant to assess sustainability of the No-Wrong-Door model. IDA will be utilizing surveys and seeking the input of the MHPC and similar stakeholder groups in the near future. IDA continues to work on the development of a single centralized database, and how to ensure that the system would be HIPAA compliant. DJ Swope is currently working on the Dementia Capable Grant, which will provide money to provide respite care to people who are caregivers to people with dementia. This would also provide training so that care providers can recognize the early signs of dementia.

Public Comment:
Jim Rixner said he is concerned with the proposed closure of two Mental Health Institutions. Jim expressed his Representative David Heaton who gave a speech on the floor of the Iowa House about his concerns related to the MHI closures. Jim also mentioned that Representative Ken Rizer from Linn County has expressed opposition to redirecting MHBG funds to the MHDS regions. Jim expressed concern about DHS not mentioning the MHI closures in their department update.

Meeting Adjourned at 3:15pm

Minutes respectfully submitted by Peter Schumacher